Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964664	A. BUILDING: _____ B. WING _____	11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF DELRAY BEACH	16150 JOG RD. DELRAY BEACH, FL 33446

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A 000	Initial Comments An unannounced Limited Nursing Services (LNS) monitoring visit was conducted on [redacted] at Arden Courts of Delray Beach Assisted Living facility. The facility had deficiencies at the time of the visit.	A 000		
AN276 SS=D	59A-36.022(1) FAC LNS - Nursing Services (1) NURSING SERVICES. In addition to any nursing service permitted under a standard license pursuant to section 429.255, F.S., a facility with a limited nursing services license may provide nursing care to residents who do not require 24-hour nursing supervision and to residents who do require 24-hour nursing care and are enrolled in hospice. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the Assisted Living Facility failed to ensure residents admitted under Limited Nursing Services (LNS) were provided with the services for 1 of 2 residents reviewed receiving LNS for the application of [redacted], Resident #3, as evidenced by wraps were not applied as ordered. The findings included: Review of the LNS Log revealed Resident #3 was receiving LNS services for the application of [redacted] wraps. Review of the physician order dated documents 'Admit to LNS. Private care giver currently apply each morning and remove at bedtime right and left Velcro wrap to keep partially open. In the absence of private duty, nurses will apply and remove right and left Velcro brace. Community nursing staff to provide daily right and left skin check.'	AN276		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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AN276	Continued From page 1 Review of the LNS Monthly Nursing Assessment completed on , the LNS Supervisor Director of Nursing (DON) documented under Nursing Services Provided: Casts, braces and , . Documentation under Specific documentation regarding LNS services provided states ' , applied to both in the morning by private care giver. No redness, no noted.' On at 10:41 AM, accompanied by the DON, Resident #3 was observed sitting in the activity room with her private duty aide (PDA) and spouse. The left and right Velcro wraps were not observed to be in place. An interview conducted with the resident's spouse at this time revealed Resident #3 had a PDA for 2 days a week on Sundays and Mondays and a different PDA comes in 5 days a week Tuesday through Saturday. An inquiry was made to PDA Staff 'A' why she did not apply the wraps to the resident's to which she stated the resident's are not so she did not apply them. An inquiry was made to the PDA if she was a licensed nurse or physician to be able to make that assessment to which the PDA stated she is a Certified Nursing Assistant and not a licensed nurse or physician. The resident's spouse at this time stated the wraps are not used because her get , it is to prevent her nails from digging into the palms of her . Resident #3's left and right were observed to have with her curling in towards her palms. On at 11:15 AM, an inquiry was made to the DON how many hours per day the PDAs for Resident #3 provide personal care to which she stated she believes the Tuesday to Saturday aide	AN276		

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AN276	Continued From page 2 works from 9:00 AM to 7:00 PM and the Sunday and Monday aide works from 8:00 AM to 7:00 PM but she was not certain and will find out. On at 12:20 PM, an interview was conducted with Resident #3's legal guardian, who arranged to have the 7 days a week care giver services, stated PDA Staff 'A' cares for Resident #3 on Sundays and Mondays from 10:00 AM to 6:00 PM. The legal guardian was apprised PDA Staff 'A' did not apply the residents , today, stating she did not apply them because the resident's were not . The legal guardian stated sometimes the resident's get sweaty, however understood PDA Staff 'A's comments did not indicate the reason she did not apply the , was sweaty . The legal guardian confirmed the wraps were ordered to prevent further and prevent the resident's from digging into her palms. Review of the Individual Service Notes from , the date of the order for the wraps, to , does not document if, when or who applied the wraps in the mornings as ordered. Review of Resident #3's Monthly Care Plan completed by the DON dated , documents under Night Time care: Resident retires generally around PM depending on how many naps she has had during the day. Private aide assists with getting her ready for bed. Further, review of the Individual Service Notes, nursing staff is documenting daily the removal of the wraps either at 11:00 PM or 2:00 AM. Review of the order for the wraps states to apply each morning and remove at	AN276		

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AN276	Continued From page 3 bedtime, which according to the resident's Care Plan is between 7 to 9 PM. On at 12:30 PM, an interview was conducted with the DON and an inquiry made how the PDAs are educated on residents current treatments, such as the application of wraps or , , to which the DON stated she has educated the PDAs. A request was made to provide the documentation to show what education was provided and to whom, to which the DON stated she does not have any documentation to show that. On at approximately 2:30 PM, the observations and findings for Resident #3 were discussed with the Administrator during the exit conference. The Administrator indicated the issues will be addressed. Class III	AN276		
AN278 SS=D	59A-36.022(3) FAC; 429.07 (3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS	AN278		

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AN278	Continued From page 4 A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to appropriately assess and monitor a for 1 of 1 residents identified under Limited Nursing Services (LNS) receiving care of a total of 8 residents receiving LNS services, Resident #4, as evidenced by failing to document the status of Resident #4's . The findings included: Review of the LNS Log revealed Resident #4 was admitted under LNS on for hospice services and on for care. Review of the LNS Monthly Nursing Assessment dated documents under LNS services provided 'Applying and changing routine that do not require packing or irrigation, but are and closed surgical . Under Specific documentation regarding LNS services provided documents - Resident admitted to hospice care. noted to forehead.' Further review of the monthly assessment did not document any assessment or monitoring of the to the forehead. On at 10:12 AM, an interview was conducted with the LNS Supervisor Director of Nursing (DON) and an inquiry was made how Resident #4 sustained an to his	AN278		

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AN278	Continued From page 5 forehead. The DON stated the resident and they applied 2 steristrips to his forehead and they are monitoring that. On at 10:50 AM, Resident #4 was observed in the activity room. A steristrip was observed on the right side of his forehead. The forehead , the approximate size of a quarter, extended above and below the steristrip and looked reddish and raw above the steristrip with yellowish red almost wet looking scab below the steristrip. An inquiry was made to the DON about the use of the steristrip to which she stated they put the steristrip on to bring the edges of the together. A further inquiry was made if the was a to which the DON stated the was an . On at 11:50 AM, a further interview was conducted with the DON and an inquiry made when Resident #4 sustained the . The DON stated she was not certain but will get the Incident Log. A request was also made to review Resident #4's clinical record. Review of the Incident Log revealed on , Resident #4 was observed on the floor of the unit he resided. Actions taken were documented as cleaning the with normal and the application of . There was no documentation or assessment of the size of the or what it looked like. There was no documentation of the application of steristrips. Review of the clinical record revealed no physician order for care, no order for the application of to the and no order for the application of steristrips to the forehead . Review of the clinical record Individual Service Notes from	AN278		

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AN278	Continued From page 6	AN278		

through [redacted] at 10:00 AM, the last entry, revealed no documentation of any monitoring or assessment of the forehead [redacted].

On [redacted] at 12:30 PM, an interview was conducted with the DON who stated the residents [redacted] was cleaned with normal [redacted], [redacted] applied and the steristrip was put on, stating the steristrip stays on until the [redacted] closes. A request was made to review the order for the [redacted], steristrip application and [redacted] care frequency. The DON stated they do not need an order for the steristrip, they do not have an order for the [redacted], and there is no [redacted] care frequency. The DON was apprised a steristrip is used when there is a cut or [redacted] and the steristrip [redacted] in the closure of the 2 edges, however an [redacted] is not a cut in the skin and a steristrip is not indicated for an [redacted]. An inquiry was made to the DON who is monitoring or assessing the resident's forehead [redacted] to which she stated the nursing staff and herself are monitoring it. The DON was apprised there is no documentation in the resident's record from [redacted] through the last entry on [redacted] and today is [redacted] with no evidence of any assessment of the resident's [redacted] for the past 8 days. The DON stated they are always checking the resident, further stating the [redacted] looks good, further stating the steristrip stays on until it [redacted] off or the [redacted] has healed. The DON stated they document for 3 days after an incident and after that they do not have to document. The DON was reminded of the observation of the resident's forehead [redacted] conducted at 10:50 AM was of an [redacted] with a steristrip over it with reddish and raw looking skin above the steristrip with yellowish red almost wet looking scab below the steristrip. The DON could not provide any documentation of any monitoring or

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AN278	Continued From page 7 assessment of the . . . . . Resident #4 sustained on . On at 1:18 PM, the DON stated she has removed the steristrip and to come observe the . Resident #4 was observed sitting in his room. The sterstrip on his forehead had been removed. The . . . was approximately the size of a quarter with the upper half with red raw looking skin and the bottom half a yellowish crusty almost wet looking scab. An inquiry was made again for the indication for a steristrip if there was no cut or . . . . . to which the DON now stated it is to protect the from . . . . . . On . . at approximately 2:30 PM, the observations and findings for Resident #4 were discussed with the Administrator during the exit conference. The Administrator indicated the issues will be addressed. Class III	AN278		